a. Has the patient now entered so imminently into the process of dying that medical treatment – as opposed to nursing care, which should always be given – can no longer benefit him or her? The irreversible cessation of activity in the brain stem is sometimes used as a criterion to answer this question.

b. Is the patient now dead? This question (which is different from the first) needs to be answered positively and with certainty before vital organs could morally be removed for transplantation.

It is always a painful thing for a family to be involved in the decision to switch off a life-support system. They depend on doctors to give them accurate medical information, in language which they can understand. Before medical interventions can be discontinued relatives need to be assured either that death has already occurred or that the patient's condition is such that these interventions do not offer hope of benefit to him or her.

A similar problem arises when a person who appears to be dying is being fed or hydrated artificially by tube. Once the process of sustaining life in this way has been begun, we need to seriously question any decision to remove the tube. In many cases, the removal of the tube would be intended to end the life of the sick person. This is a form of euthanasia, and is incompatible with our duty to respect life.

In a small number of cases, however, as death approaches, tube feeding may unnecessarily increase suffering with no benefit to the patient or may even inadvertently hasten death. If the tubes are removed, not in order to hasten death, but because the tube feeding is not beneficial or may even be harmful to the patient, this would not be euthanasia.

This raises another important question, namely that doctors and nurses sometimes feel that they have to do 'everything possible' even if it is not in the best interests of the patient. People, understandably, want the best possible care for their relatives who are sick. Sometimes the 'best possible care' is to recognise that life is coming to an end, and to make the sick person as comfortable as possible in the last hours and days, without any dramatic medical interventions.

Respect for life is fundamental to the ethos of medicine and nursing

Spiritual and Sacramental Care

A person who is dying is more than just a sick body. Every person is created for relationship with God. The last days and weeks of life are the closing stages in a lifelong journey. We Christians, in common with many others, believe that this journey finds its fulfilment in eternal happiness with God. Once the initial shock of life-threatening illness has been dealt with, people who are sick can often be drawn to reflect on the meaning of their lives and on their relationship with God. This is often a time for giving thanks, and for reconciliation. Good palliative care, because it frees the sick person from excessive anxiety or pain, facilitates good pastoral and sacramental care.

The sacraments of the eucharist, of reconciliation, and of the anointing of the sick have an important part to play in the care of a person who is sick. These sacraments are our way of celebrating the presence of God who brings his gifts of inner healing and strength to the person who is sick. They are also a mark of the fact that sick people continue to belong fully to the community of the Church, even though they may not have been able to join in the activity of that community for some time.

In writing this letter, we wish to join in solidarity and prayer with those who are seriously ill, and with all who care for them, whether at home or in hospital. The practical and emotional burdens which you bear, in many cases, are known to God alone. Our prayer for you is perhaps best expressed in the words of Cardinal Newman: *May He support us all the day long, till the shades lengthen and the evening comes, and the busy world is hushed, and the fever of life is over and our work is done! Then in His Mercy may He give us a safe lodging and a holy rest and peace at the last.*

Quite apart from any question of morality, good palliative care should mean that there is no need for euthanasia

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VERITAS

Living with Dying

A Letter from the Irish Bishops to mark the Day for Life October 2002

Dying is Woven into Life

As a nation, we Irish probably go to more funerals than most people. In that sense, death is familiar to us; it is woven into the very pattern of our daily lives. But when we are faced with the death of a family member, or indeed our own death, it is a radically different experience. It brings with it a strange mixture of feelings: fear and hope, sadness and surprise, intimacy and isolation. It can also bring about a radical change in the lives of those who are left behind.

When Someone you Love is Dying

When someone in a family is dying, it often happens that everyone ends up 'walking on eggshells'. We haven't worked through our own feelings, so we don't trust ourselves to talk about them. We try to protect one another from the unwelcome truth that someone we love is dying. All of that can be very stressful.

People who are dying may not want to focus too closely on what is going to happen, but they usually do want people to be honest with them. They want to be listened to as they talk about their hopes and fears. If every quiet moment is filled with assurances of a 'speedy recovery' it may be far more difficult for a person to come to terms with what is happening. People who are dying want to know that, even though there is no prospect of recovery, they will not be abandoned. Palliative care is about nurses and doctors, family members and friends, chaplains and counsellors working together to ease the anxiety and the pain of a person who is dying. The life and dignity of the sick person is respected and supported until death comes naturally.

Communication or Sedation?

If someone who is dying becomes anxious or distressed, it may sometimes be necessary to prescribe some sedatives which will calm him or her. But sedatives also make people confused, and this deprives them of whatever limited control they have over their own

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It is important that the kind of care a sick person receives is not dictated by the fears or the convenience of others

situation. Often the cause of the distress is something practical. As life draws to a close, people sometimes experience the need to deal with unfinished business, whether that has to do with family, or work, or indeed God. If a sick person can be helped to do whatever needs to be done, the anxiety may be resolved without the need for sedatives. It is important that the kind of care a sick person receives is not dictated by the fears or the convenience of others.

Controlling Pain

Nowadays, it is possible in most cases to keep pain within reasonable limits, by the use of drugs. The drugs which are used to control pain do have side effects. They can affect the appetite and depress the breathing. While the patient's quality of life is improved he or she may die a little sooner due to these side-effects. Under the traditional moral Principle of Double Effect, such drug treatment is perfectly legitimate from a moral point of view, provided that:

- there is no intention to end the life of the person who is dying, and
- the reduction in the patient's length of life is not out of proportion to the pain-relief he or she experiences.

Pain-relief is a normal part of medical treatment. It is not euthanasia. We very much welcome the fact that more doctors and nurses are being trained in pain-control and are available to support people who are dying and their families, both in hospices and in the community. Ideally every general hospital should have a palliative care specialist among its staff.

Euthanasia

Respect for life is fundamental to the ethos of medicine and nursing. We depend on doctors and nurses to respect life. Euthanasia would greatly undermine the relationship of trust between patients and healthcare professionals. The integrity of doctors and nurses would be placed at risk, just as it has been in many places through the legalisation of abortion.

Under serious emotional pressure, a person might easily say 'I wish I were dead'. It would be strange if people who are terminally ill did not, at least occasionally say 'I wish I were dead'. But we need to recognise that there is a difference between feelings and decisions. Usually what a person means is 'I wish I didn't have to go on living like this'. If someone does request euthanasia, our first response must be to see if there is some issue which needs to be dealt with, either through counselling, through sedation, or through adjusting the level of pain-control. Quite apart from any question of morality, good palliative care should mean that there is no need for euthanasia.

When a decision is taken to terminate the life of a person who is sick or elderly, on the grounds that his or her life is no longer worth living, this is euthanasia. Whether it is by doing something, or by doing nothing when something should be done; be it with or without the consent of the person who is killed, euthanasia comes down to the same thing in moral terms. It is the deliberate killing of a human being, and it is contrary to the law of God.

God is the giver of life, and he alone has the right to decide when a life should end. There is a recognisable pattern of emotions through which most people go, during terminal illness. It begins with shock, passes through stages of denial, anger, and bargaining, and tends to arrive eventually at calm acceptance. If our response to the patient's anger or denial is euthanasia, the sick person will remain in that anger or denial, and will never reach the final stage of calm acceptance.

Difficult Decisions about Life-Support

Over the years our understanding has changed to some extent regarding the moment of death. Death means that the human body has irreversibly ceased to operate as an organic whole. Adequate criteria need to be properly applied in determining two distinct questions:

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